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Committee on Government Reform Briefing on the Medicare Drug Plan
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Thank you Representative Waxman and other members of the Minority Office of the House Committee on Government Reform for this opportunity to provide information and insights on economic and policy issues related to Medicare Part D drug program. I am Stephen W. Schondelmeyer, Professor of Pharmaceutical Management & Economics at the University of Minnesota where I serve as Director of the *PRIME* Institute. This Institute focuses its research on policy issues related to pharmaceutical economics and the management of drug expenditures at all levels in the society. These remarks are my own views based upon my experience in studying the pharmaceutical marketplace for over twenty-five years and upon my observations of the new Medicare Part D drug program during its preparation phase and in the past few weeks now that it is being implemented.

This briefing on the Medicare Drug Benefit provides a timely forum for examining the successes and failures of this new program as it is being rolled out. Also, this hearing provides an opportunity to look ahead to what we can expect from the Medicare drug benefit in the years ahead, if the current structure of the program remains in place. Today, I will briefly address both short-term and long-term economic impact issues of the Medicare Part D drug program.

Economic Impact of Eligibility Problems

First, let me begin by commenting that coverage of prescription drugs under the Medicare program is, in general, a major step forward for providing appropriate and accessible drug therapy to the nation's elderly. Any public program that is intended to do good things for members of society may achieve its stated objectives and it may have difficulties and problems that were unintended. The difficulties and failures experienced by a public program may result from implementation failures, policy failures, or both. However, it is important to distinguish between those problems that are due to implementation from those that are due to policy failures.

Obviously, the start of the Medicare Part D Drug program has experienced unexpected and unintended difficulties. Others on today's panel have commented on the failure of the Medicare program to properly enroll and provide eligibility information on dual eligibles when they went to the pharmacy to have a prescription filled. This situation is primarily the result of an implementation failure. The consequences of this failure, however, go deeper than may be realized. First, many elderly beneficiaries went to the pharmacy to get a needed medication, only to find out that the pharmacy could not verify their eligibility and had no way to identify in which of the 40 to 70 specific prescription drug plans the Medicare recipient was automatically enrolled. The pharmacist then tries to call either Medicare or one of more of the prescription drug plans (PDPs) that received automatic enrollees. The call lines have been greatly overloaded in the past few weeks and pharmacists may be put on hold for hours by the PDPs or Medicare. This adds time and cost to the pharmacies operation that will never be recovered. In most cases, the pharmacist filled the prescription for the beneficiary even without the needed information or authorization and gave the medication to the patient.

Although all stakeholders are important to the Medicare prescription drug program, the pharmacist is literally the FACE OF THE MEDICARE DRUG BENEFIT to each and every beneficiary. This initial experience, however, created a tension-filled situation for both patients and pharmacists due to no fault of either one. After the patient leaves the pharmacy, another unintended economic consequence develops. A pharmacy can fill a few prescriptions over a few days for a few patients and figure out how to get reimbursed later without major harm. In this case for many pharmacies, many patients were not in the system as eligible and the problem has persisted for two weeks or more. Pharmacies are beginning to experience downstream economic problems. The pharmacy has to order drugs to replace those that have been dispensed, even though it has not been paid for the drugs already provided. The usual payment terms from the wholesaler require the pharmacy to pay for the new stock within 2 weeks. If the wholesaler is not paid in two weeks the pharmacy may suffer economic harm thorough loss of timely payment discounts (i.e., about 2%), taking out a loan or line of credit advance to pay the wholesale bill, pay penalties for late payments, or lose their credit and ability to purchase from the wholesaler. Pharmacies are reporting that their wholesalers are not being flexible about payment for prescription drug orders due to this difficult Medicare situation. This situation has already caused economic harm to community pharmacies and the longer it continues, the more severe the impact will be. Especially hard hit by this situation will be the smaller pharmacies which tend to be in rural or low income areas. This added economic impact from eligibility problems and substantially delayed payment will further compound the concern of pharmacies, and especially those in rural and underserved areas, with the very low payment levels from most PDPs.

Economic Impact of Medicaid to Medicare Shift

In addition to the implementation failure related to dual eligibles, there is a deeper underlying policy failure with the conversion of dual eligibles from Medicaid to Medicare. Prescription drugs paid for under the Medicaid program cost the government less than the same drug will cost under the Medicare program. This cost difference is due primarily to the loss of revenue from the Medicaid drug rebate program with minimum rebates of 15 percent or more and additional rebate payments for best price and inflation adjustment over time. The total rebate may be as much as 20 to 30 percent of the drug product cost. While the private PDPs under the Medicare program may negotiate rebates, any benefit from such rebates that is not passed on to the beneficiary in the prescription price will not be realized by Medicare or the patient. There is no direct mechanism for a drug company or the PDPs to pass rebates on to the Medicare program.

The prices of 25 top prescribed brand name drugs were examined for all PDPs offered in one zip code in Minnesota during the first two weeks of 2006. Based on the total prescription prices found on the CMS website for each of the 41 plans, several general observations were made. Most of the plans had prices posted that were within plus or minus 4 percent of the typical retail price (see Figure 1). The Medicare prices posted were 14 percent to more than 50 percent

above the prices that the government would have paid under the Medicaid program. Most of the Medicare prescriptions were 20 to 30 percent above the Medicaid price for the same prescription.

Knowledge that the Medicare program will be paying more for the same drug than the Medicaid program would have paid has not gone unnoticed by the pharmaceutical companies. At least one drug company has acknowledge to Wall Street that it expects an increase in revenue and earnings due to the higher price it will be paid for prescriptions received by dual eligibles under Medicare versus the price they would have received under the previous Medicaid program.[1] As reported, "the transfer (of dual eligibles) means *Zyprexa* will escape from the Medicaid rebate system, which requires Lilly to pay the government back for any inflationary price increases for the product. Lilly expects a 'modest, one-time price benefit' from that change alone, CEO Sidney Taurel said." Taurel went on to say that "now is probably not the time for headlines suggesting that drugs will be costing the federal government more in 2006 than they did in 2005." This increase in cost of prescriptions for dual eligibles appears to be a policy failure with respect to the design of the Medicare drug benefit.

Not only does the Medicare program lead to higher payments for prescription drugs versus the previous Medicaid system, but the structure for delivery of the private benefit by many entities (i.e., 40 to 70 or more PDPs and managed care plans) will not likely achieve better prices than Medicaid at any point in the future without structural change to the Medicare drug program. To the degree that market leverage and volume influence drug prices, the Medicare drug program will be delivered by many smaller plans within each state, rather than by one large plan (i.e., Medicaid). This smaller volume and diminished market power for the many PDPs is not likely to generate discounts and rebates from manufacturers that approach the historical rebate levels specified under the Medicaid program.

Economic Impact from Plan Choice

Theoretically, the consumer's choices among PDPs and the posting of prescription prices for each PDP could create competition and pressure on prescription prices. However, effective competitive pressure is not likely to occur. The 40 to more than 70 plans available to seniors in a specific region each have different benefit designs and different levels of premiums, deductibles, coverage gaps, copays, coinsurance, and prescription prices. Most seniors when faced with this complex array of information focus on only one or two of these factors when choosing their Medicare PDP. One source has suggested that "the premium is the first element price-conscious consumers will consider."[2] Choosing a plan based only on the premium may not result in the best choice for all beneficiaries or for the Medicare program as a whole. Another feature that often gets the attention of persons trying to chose among plans is the out-of-pocket amount to be

[1] "Lilly Makes Part D Pay," *The RPM Report* (Windhover Information Inc.), Vol. 1, No.2, January 2006, p.34.
[2] "Playing Offense in Part D: Three Aggressive Medicare Strategies Demand Pharma Attention," *The RPM Report* (Windhover Information Inc.), Vol. 1, No.1 December 2005, pp.23-31.

paid as copays and deductibles. Again this is a useful criteria for comparing PDP plan offerings, but the choice of a PDP based solely on the out-of-pocket costs of various PDPs may not lead to the best economic choice for a specific beneficiary or for Medicare. Furthermore, if a beneficiary chooses a PDP that is best for them based on copays and drug coverage at the beginning of the year, they may find that the PDP has changed the formulary, drug prices, and copays by the end of the year in such a way that the plan is no longer the best choice for that person.

In reviewing the information posted on the CMS web site for PDPs in a specific a region, there was inconsistent information that appeared to include either coding or calculation errors. On the one hand, errors are not unexpected in such a massive program. However, the errant information may was present during the entire period when beneficiaries were making their initial choice of PDPs, and may well have inappropriately steered them from one plan to another based on 'bad' data. Some prescription drugs, for example, had prescription prices listed that were greatly different from other plans (e.g., one-fourth of the price of other plans) and appear to have been copay information entered in the prescription price file for certain plans and not others. Most beneficiaries would not systematically review all plans and all prescription prices to catch these errors. Competition can not possibly work with bad or incomplete information.

In the past few months, I have had the opportunity to meet with many beneficiaries, pharmacists, and physicians in groups or individually. The feedback from these groups is almost always the same. The Medicare drug program is complex which leads to confusion then frustration and ultimately results in anger and desperation. Others have described the various ways that these frustrations develop. This complexity though also leads to market conditions that are not conducive to economically efficient competition.

Three American economists were awarded the Nobel Prize in Economics in 2001 for their work in defining the impact of asymmetric markets such as "The Market for Lemons" or also known as 'used cars'.[3] Asymmetric markets are markets with imperfect and incomplete information for certain participants. The market for pharmaceuticals was already an asymmetric market, that is, an imperfect market in which certain participants, such as drug manufacturers and prescription drug plans, know far more about their products than do consumers. The Medicare Part D Drug Program has added to the imbalance in market information and understanding through complex and widely varying plans, incomplete and changing information on plans, and lack of transparency.

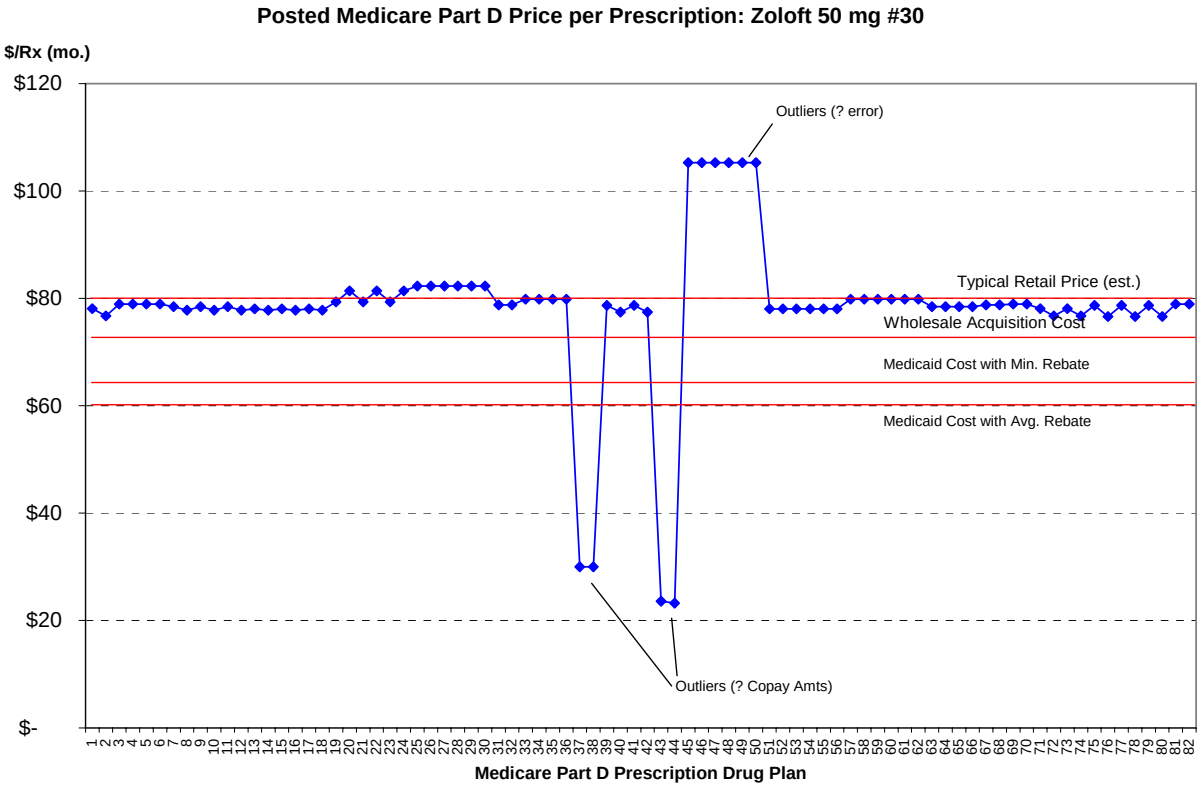
The three American Nobel Laureate economists pioneered the view that "markets, when confronted with imperfections, may not be the best way to allocate resources."[3] These economists concluded that "government must play a strong role in a market system, to prevent damage from imperfect information." When one part of the market knows more than another, it

[3] "3 Americans Awarded Nobel for Economics," New York Times, October 11, 2001.

not only explains various corporate strategies, but it also justifies government intervention. Government intervention has been needed in many markets to correct for imperfect information. Various actions of government that may help the current Medicare situation include increased transparency and disclosures, establishment of one or more standardized drug benefit designs, provision of additional tools to assure efficient purchasing and distribution of pharmaceuticals, and other actions to assure that the Medicare program does provide appropriate and accessible drug therapy in an economically efficient manner through a care process that assures improved health status for all beneficiaries.

Thank you for your time and for the opportunity to give you input on economic and policy issues related to the important Medicare Part D drug program.

Figure 1.



Source: Prescription prices found on CMS website Jan 11, 2006 for PDPs and pharmacies in rural Minnesota within zip code 55730.